

MACROECONOMICS AND HEALTH
INDONESIA
Country Profile

1. Macroeconomic Context

Since the economic crisis in 1997-8, the Government of Indonesia has rigorously promoted political stability and sound economic policies that resulted in a modest social and economic recovery with a relatively stable local currency. Modest economic growth was reported in 2002 and 2003. External debt has declined rapidly from 91.6% of GDP in 2001 to 75.6% in 2002.

Indicators	
2002 Population	211 million
1990-2000 Pop. Growth	1.35%
2002 Gross National Income Per Capita	US\$ 710
GDP Growth	3.7%
Consumer Price Index (2002 average)	11.9%
Unemployment (2/03)	8.5%

Poverty has declined rapidly after the economic crisis. A large proportion of the population, however, live at less than US\$ 2 per day, suggesting that even small changes in food prices and household shocks can impact poverty. Progress on non-income measures of poverty remain slow.

The health sector in Indonesia fares less favorably than the overall economy as reflected in the health expenditure table. A major constraint is the continued low level of funding to the health sector.

In 2001, total spending on health amounted to an estimated 2.6% of GDP in Indonesia compared with 5.5% on average among developing countries worldwide. This translates to about US\$ 16 per person, approximately 63% of which originates from individual out-of-pocket expenditures. From the international community, the contribution to health is similarly inadequate.

Health Expenditure 2001	
GDP for Health	2.6%
Of which public	36.9%
US\$ per capita for health	16
ODA devoted to health	6%
Gov't expenditure as a GDP percentage	0.9%
Per capita expenditure on health by Government	11.3%

Overseas development assistance (ODA) to Indonesia averaged US\$ 1.5 billion in 2001, of which only 6% was dedicated to the health sector. A much higher level of resources needs to be mobilized from domestic and international sources.

Indicators (2001-2)	
Population under US\$2 per day (2002)	58%
Under 5 with low weight for age	27%
Infant mortality per 1,000 births	44
Under 5 mortality per 1,000 births	44.7
Children immunized against measles	72%
Maternal deaths per 100,000 births	334
Births attended by midwives	69%
Tuberculosis incidence (SS+)/100,000	271
Tuberculosis Prevalence/100,000	786
Tuberculosis cases detected	29%
Tuberculosis cases treated successfully	86%
Malaria prevalence/100,000	850
Population with access to water	79%
Population with access to sanitation	64%

2. Background to Health Sector Financing

The Government of Indonesia made substantial development progress, with GNP per capita increasing rapidly between 1970 and the early 1990s. Health status also improved remarkably. Whereas a child born in Indonesia in the 1960s could expect to live 46 years, one born in 1996 could expect to live for nearly 65 years.ⁱ Although difficult to measure, such achievements were due in part to health investments that expanded access to basic services. The total fertility rate, for example, declined from 5.6 in the 1960s to 2.6 children per woman today.ⁱⁱ This decline was largely attributable to increased contraceptive use.ⁱⁱⁱ

Indonesia invested considerable public funds in health and social services during the 1970s and 1980s. Such investments matched international commitments to expand basic social services, primarily via the public sector, and were largely comprised of infrastructure and equipment for improving access to basic services.^{iv} For example, the Government nearly doubled the number of public health facilities between 1974 and 1995 to more than 7,000 health centers and 20,000 auxiliary health centers. The aim was to extend the reach of modern medical care to the whole population while keeping fees low to encourage use. Between 1987 and 1992, the average distance to a modern facility fell by about 50 percent.^v The result today is a vast tiered network of public health facilities, although the number of beds per 1,000 persons remains low (0.7) compared with developing countries on average (2.7).^{vi} Government health spending per capita nearly doubled between 1987/1988 and 1992/1993.^{vii}

In 1997 and 1998, the economic crisis exposed the vulnerability of funding to the health sector. The value of the currency plummeted, prices increased, and unemployment rose. Real per capita Government spending in the health sector declined, and health spending in 1998/1999 matched levels achieved in 1992-1993.^{viii} Trends demonstrate that the decline in utilization of modern medical care since 1995 was exacerbated by the crisis and this factor remains vulnerable with the implementation of fiscal decentralization policies in 2001.

Since the economic crisis, the Government has been striving to improve overall health status via clear policies and corresponding financial commitments that promote good health, particularly among the poor. The Government and the Health Working Group, comprising all major donors to health, have worked together to propose areas of collaboration with the aim to further understand and gain consensus on the best ways to integrate pro-poor policies and strategies into existing health systems. Over the long-term, such strategies and policies would be the basis for a much-needed increase in the amount and effectiveness of domestic and international funding for key health interventions.

A further challenge to the health sector is the ongoing process of fiscal decentralization in 2001, which transferred authority and resources from national to the local government for 11 sectors, including health. The decentralization policies present new opportunities for revitalizing the health sector as well as several important challenges. Under the current **fiscal decentralization** policy, much of the funding for health will rely on support from the district government, the negotiating strength of health authorities, and the population's vocalized priorities. Yet, an important conflict of interest exists where user fees from public facilities are a source of local revenue. The need exists to establish political commitment and an effective

institutional environment so that essential health interventions and public goods are accessible and affordable, and national commitments for poverty reduction fulfilled.

Human resources are the central input to an efficacious health system. Financial pressures combined with new organizational structures reinforce the need for a critical evaluation of workforce needs, management, and deployment. Such restructuring may offer an opportunity to address the persistently low wages, particularly among peripheral level staff, that effectively prevent the development of a professional full-time cadre of health professionals and, in the long run, promote overstaffing in urban and highly populated areas where private practice may be more lucrative. Providing incentives for posting qualified staff to remote areas remains an important challenge.

Under decentralization also comes **greater accountability** to households and individuals, who require accurate information to make informed decisions about behavior that affects health such as seeking quality care and medicine, smoking, and exercise. There is a need to support the full and active participation of the community within priority setting, planning of health activities, and feedback into management, in addition to the promotion of active and well-educated consumers of care.

3. Macroeconomics and Health (MH) Work in Indonesia

The Government of Indonesia is undertaking a number of important initiatives associated with health and poverty. These initiatives, however, could be better integrated within overall policy framework under which to provide common direction and understanding of the nature of poverty and health in Indonesia. With MH support, three overall objectives have been proposed:

- a) To accelerate existing initiatives that support capacity building activities in achieving pro-poor policy and funding commitments in line with the MDG goals and the Government poverty reduction strategy framework, including the workplan proposed by the Consultative Group on Indonesia (CGI) under the Government's poverty reduction strategy.
- b) To provide the Government with access to timely and focused research and technical support with which to address systemic issues in integrating specific pro-poor health policies and initiatives into existing policy processes and health systems, such as the SKN (national health system initiative) and Healthy Indonesia 2010.
- c) To increase knowledge and political commitment among policy makers, government officials, and the public about health, economic development, and poverty reduction.

The findings and recommendations from this work would be the basis for a) gaining pro-poor commitments within the executive and legislative branches; b) defending a significant increase in domestic and international funding, and c) ensuring that funding matches poverty priorities, and d) incorporating poverty priorities into government policy processes and budgets over the medium and long-term.

4. Health and poverty reduction

4.1 The importance of health within the Government's poverty reduction and development programme

Poverty is multidimensional, and health is a central aspect.^{ix} Healthy, well-nourished children miss fewer days from school and have a better ability to learn. Healthy adults contribute to a productive workforce, which is a building block for economic growth and may attract a higher level of foreign investment. At the population level, the reduction of childhood illness and death combined with declines in fertility leads to a larger proportion of people living longer and with more productive lives.^x Good health provides people the physical capability to fully participate in the social and economic community.^{xi} Effective health interventions, therefore, are a central means of realizing the Government's goal of reducing poverty.^{xii}

The loss to the economy from ill health is enormous. Tuberculosis is a good example. Every year, nearly 600,000 new tuberculosis cases occur in Indonesia.^{xiii} Most of these cases are among working age adults, who lose, on average, three to four months from work. Effectively controlling the spread of tuberculosis would positively affect the whole communities, which would be no longer exposed to the risk of tuberculosis, contribute to a more productive workforce and reduce the global burden of the disease. Similarly, HIV/AIDS predominantly affects the young and most productive members of the society. An estimated 80,000 to 120,000 Indonesians are currently living with HIV/AIDS.^{xiv} The loss from illness due to malaria is conservatively estimated at more than 334,000 disability-adjusted life years, which amounted to a financial loss from household income of US\$ 190.8 million.^{xv} This does not take into consideration revenue lost from tourism and foregone business investment in malaria endemic areas. Furthermore, resistance to existing cost-effective drugs has been reported in all provinces, due to inadequate treatment compliance, inappropriate self-medication and high population mobility.

Many of Indonesia's health problems – tuberculosis, malaria, infant and maternal mortality, and malnutrition – are problems from which the poor suffer disproportionately. Poor households have fewer resources for health, are more vulnerable to disease and have less access to health services, clean water and sanitation. Indeed, Indonesian children from the poorest families are nearly four times more likely than children from the richest families to die before their fifth birthday.^{xvi}

Basic health interventions, however, are not reaching the poor. The proportion of pregnant women who delivered with a trained attendant is 21% among the poorest women and 89% among the wealthiest.^{xvii} The maternal mortality ratio reflects women's access to functional referral systems and quality care at all levels of the system. Indonesia, however, lags far behind its neighbors, with the highest maternal mortality ratio in the Southeast Asian region.^{xviii} Clearly, making essential health interventions accessible for Indonesia's poor requires appropriate policies, strong commitment, and a higher level of resources.

4.2. The Government Reduction Strategy Framework: where does health fit?

The Government of Indonesia places poverty reduction efforts as a development priority, with overall aims to reduce the absolute number of poor via the Poverty Reduction Strategy (PRS).^{xix} The PRS aims to increase the poor's income and reduce the poor's expenditure on basic needs. The PRS will be implemented through four main strategies, with the overall aim to achieve the Millennium Development Goals (MDGs):^{xx}

- **Creating opportunities for the poor** within an overall environment conducive to economic growth and poverty reduction.
- **Community empowerment** whereby the Government, private sectors and the community empower the poor so they can attain their economic, social, and political rights, are in charge of every decisions that impact on their future, express their aspirations and identify their own problems and needs.
- **Increasing human capital and capacity** in which the Government, private sectors, and community assist in building the poor's capacity to increase work productivity, and to work out their own needs.
- **Providing social protection** whereby the Government invites the private sectors and the community to provide social protection and security for the poor.

To increase the efficiency and effectiveness of ongoing poverty reduction efforts, the health policies and programs need to fit within the four strategies above.

Figure 4. The poverty reduction strategy: where does health fit?

Creating opportunities	<i>Empowering communities</i>	Increasing human capital and capacity	Providing social protection
<p>Ensure an effective institutional environment under decentralization</p> <p>Optimize the participation of private and non-governmental providers</p>	<p>Ensure accountability by local government for health systems at all levels by engaging a broad range of stakeholders including the poor</p>	<p>Ensure resource allocation and improve funds channeling for priority health programs</p>	<p>Reduce financial vulnerability to major medical expenses and protect the interests of the poor</p>

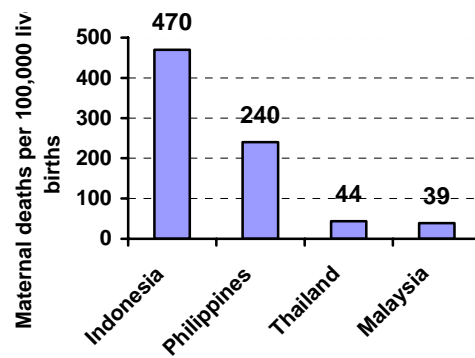
4.3 Most households are vulnerable to unpredictable health expenses because of severe illnesses.

On any given day in Indonesia, healthy people are injured in accidents and experience sudden severe illness. These health shocks can drive even the non-poor into poverty, particularly because hospital insurance coverage is low.

Despite the demand, health insurance is largely unavailable to the majority of people.^{xxi} Seeking financial security against the unpredictability of poor health, most Indonesian families insure themselves informally via savings, credit markets, or borrowing from family or friends. These methods, however, are inadequate protection from financial loss due to severe illness.^{xxii} For severe illnesses, individuals may forgo education, or productive household or business assets, thereby reducing the potential for future income.

The risks are very real indeed. Approximately 58% of Indonesians live on less than US\$ 2 per day.^{xxiii} Most of the population, therefore, is highly vulnerable to poverty and debt because of unpredictable severe illnesses or accidents. Effective health financing systems are required to protect individuals from the unpredictability of health shocks, particularly from paying at the point of use when individuals may be the most vulnerable financially. It is currently estimated that more than 60% of total health expenditures are from out of pocket payments.^{xxiv}

Figure 2. Maternal mortality ratios for Southeast Asian countries



5. Shared program of work to achieve national and international commitments to health and poverty reduction under the Consultative Group on Indonesia (CGI)

The National Development Program 2000–2004, the Healthy Indonesia 2010 Strategy, and the MDGs for health focus on conditions that represent a large proportion of the disease burden, in addition to public health activities that benefit the society. The CGI Health Working Group aims to strengthen the policy framework and funding commitments to these programs. Through the Working Group, the Government and international donor community in health have agreed upon a long-term goal, purpose, and six objectives to achieve national and international health commitments:

Goal: To fulfill Healthy Indonesia 2010 and the health-related MDGs by making decentralized health systems work, especially for the poor and vulnerable.

Purpose: To mainstream health into the national development agenda and significantly increase the amount and effectiveness of funding for health.

Objectives:

1. Reduce financial vulnerability to major medical expenses and protect the interests of the poor.
2. Optimize the participation of private and non-governmental providers in contributing to implementation of national health priorities including services for the poor.
3. Improve governance and ensure an effective institutional environment (legal and structural framework) under decentralization, to support pro-poor health programs.
4. Ensure resource allocation and improve funds channeling for priority health programs, especially for the poor.
5. Ensure access to affordable, quality services, especially for the poor.
6. Ensure accountability by local government for health systems at all levels by engaging a broad range of stakeholders including the poor.

Multiple strategies and collaboration are required by a range of stakeholders to achieve progress. A brief progress report on achievement of each of the objectives is presented below:

5.1 Reduce financial vulnerability to major medical expenses and protect the interests of the poor

The issue. Despite the demand, health insurance is largely unavailable to the majority of people.^{xxv} Seeking financial security against the unpredictability of poor health, most Indonesian families insure themselves informally via savings, credit markets, or borrowing from family or friends. These methods, however, are inadequate protection from financial loss due to severe illness.^{xxvi} For severe illnesses, individuals may forgo education, or productive household or business assets, thereby reducing the potential for future income. The risks are very real indeed. Approximately 58% of Indonesians live on less than US\$ 2 per day.^{xxvii}

Only about 16% of the Indonesian population has some type of health insurance, with two social health insurance schemes cover approximately 8% of the population.^{xxviii} Most households, therefore, are financially vulnerable should family members experience medical catastrophes requiring hospitalization or expensive treatments. Furthermore, high inpatient costs are a financial barrier to accessing inpatient care among the poor, even in public hospitals. Effective health financing systems are required to protect individuals from the unpredictability of health shocks, particularly from paying at the point of use when individuals may be the most vulnerable financially. As mentioned earlier, more than 60% of total health expenditures are comprised of out of pocket payments.^{xxix}

Progress to date. Work is underway via a Task Force on Social Security Reform established by the President to draft the laws that form the legal foundation for health insurance as part of the National Social Security System, and includes establishing the fundamentals of a Social Health Insurance as law. The Task Force has recently presented a bill to the Parliament. The Health and Social Welfare Commission (7) of the Parliament initiated at the end of July 2003 its own bill for social health insurance. Both emphasize integrating public and private formal employees into one national scheme with uniform benefits governed by a board representing employees, employers, and the Government, reporting directly to the President.

External support to the process. The institutional changes and capacity required to implement national health insurance are enormous and need to be phased in over one decade or more. The donor community is supporting a donor mapping of current activities, which will lead to an identification of progress made in key areas and where further support is needed. During the transition to the National Health Insurance, it has been proposed to evaluate the feasibility of a Health Social Safety Net as a method to protect individuals from poverty due to major medical expenses.

5.2 Optimize the participation of private and non-governmental providers in contributing to implementation of national health priorities including services for the poor

The issue. There is an assumption that large-scale technical programs delivered through public facilities will be used to expand access to basic services, particularly given low infrastructure investments relative to other countries. Particularly, under a decentralized system, the temptation exists to build additional health facilities in order to expand coverage. A key question is sustainability. A recent World Bank study estimated that the costs of rehabilitating and re-equipping the existing public health system to meet existing and future basic health needs of the population are prohibitive, let alone considering coverage expansion. Construction and rehabilitation of existing public facilities not only would be very costly, but can also lead to problems of sustainability without consideration of activity levels required to justify additional capital investments, maintenance and operational costs, and accompanying human resources needs.

One alternative is to encourage private sector collaboration for national health priorities and goals. Making use of private providers for the delivery of essential services may increase efficiency and productivity within both public and private sectors. Private health care providers are a significant part of the health care delivery system in Indonesia. Private spending on health has accounted for 70 to 80% of total health spending since the 1990s.^{xxx} The Ministry of Health recognizes the private sector as a partner in the provision of health services, and encourages households to contribute to the cost of their care when they can afford it. A number of formal mechanisms for cooperating with the private sector have been developed to attract resources and increase quality and distribution.

Progress to date. The Ministry of Health offers incentives to private providers for the provision of preventive care, such as supplying free vaccines provided that they are available free of charge. It provides tax breaks to private hospitals as an incentive to follow regulations regarding services and reserved beds for the poor. Such arrangements aim to encourage private expenditures on health. Other examples of

publicly financed private services include private beds in public hospital, contracting out public (usually non-clinical) services, and government purchased insurance that can be used for private services.

External support to the process. Some pilots and research initiatives have been taken by international agencies. Two consultants have been contracted by WHO to examine international and domestic experience to date. The World Bank has done significant work in this area, with a focus on private investment in hospitals. A World Bank consultant is developing surveys to examine consumer perceptions and quality, and also make recommendations for pilot initiatives in World Bank project areas. The United States Agency for International Development (USAID) has promoted specific pilot exercises, such as franchising for clinical (midwifery) services, and consumer organizations. Despite some innovations, there has been no systematic evaluation of the impact of these policies and practices. Knowledge of the advantages and benefits of different service delivery options is particularly important in a context of administrative decentralization, where alternative measures may be needed in environments where governance is poor.

5.3 Improve governance and ensure an effective institutional environment under decentralization (legal and structural), to support pro-poor health programs

The issue. The implementation of Decentralization Laws in 2001 present new opportunities for revitalizing the health sector as well as several important challenges for the health sector. An estimated number of 16,000 service facilities were transferred from central to regional governments after the implementation of decentralization laws in 2001. Under decentralization, much of the funding for health will rely on support from the district government, the negotiating strength of health authorities, and the population's vocalized priorities. Yet, an important conflict of interest exists where user fees from public facilities are a source of local revenue. Many district governments have already increased user fees without adequate methods in place to exempt the poor and basic services.

Progress to date. There are ongoing efforts to modify the laws on regional autonomy to specify which functions are decentralized to the regional government in the 11 sectors, rather than simply identifying which sectors are decentralized. The Ministries of Health and of National Education were selected to participate in the Ministry of Home Affairs Model-Building Exercise. This exercise aims to develop the legislative and regulatory framework in collaboration with selected provinces and districts, and to give guidance to the other sectors as they develop obligatory functions, services, and associated standards. The Ministry of Health has developed a list of obligatory functions, essential health services and associated minimum service standards through a consultative process. The Ministry's Decentralization Unit has conducted leadership training for senior ministry staff, a model-building exercise to assist provinces, districts, and municipalities in clarifying the definitions of obligatory functions and minimum service standards and establishing monitoring and evaluating their achievements. It is anticipated that the work of the Ministry of Health will ensure that health concerns are reflected in modifications of the existing

decentralization laws. Information needs have also changed in light of the new roles and responsibilities at each level of the system. It is essential to build district capacity in health information collection and use, and to use such information to inform planning and funding decisions, which affect the success of national and local health goals.

With regard to monitoring national and international commitments, both the health and poverty working groups under the CGI emphasize MDGs. The Government is developing a national MDG report, under the lead of the Ministry of Planning. Complementary to this process is the monitoring of the MDGs at provincial and district level.^{xxxI}

External support to the process. The CGI working group on decentralization is active and co-chaired from Regional Autonomy and the German Technical Cooperation Agency (GTZ). The World Bank has just produced a comprehensive report on decentralization in Indonesia, with recommendations for supporting health and education as priority social sectors.^{xxxii} Specific to the health sector, World Bank Indonesia is updating its report on decentralization and health. Additional consultations about the obligatory functions (OB-Funt) and minimum service standards (SPM) for health will be held in South Sumatra, with the support of Management Sciences for Health (MSH), and in other donor supported provinces, including West Kalimantan, and Southeast Sulawesi. In addition to piloting the minimum service standards in project-supported areas, MSH/USAID has provided strong support to this process, including technical assistance in preparing academic papers to review and recommend revisions in the national health law and health system in order to more effectively address the challenges to be faced during decentralization. They are also developing and field testing a manual for monitoring and improving the performance of the obligatory basic health services.

With regard to monitoring, a UN task force under the UN Children's Fund (UNICEF) continues to support the Government national team in preparing the MDG report of the Government of Indonesia. A initiative of the Canadian International Development Agency and WHO aims to make recommendations to the Central Bureau of Statistics in modifying existing data collection instruments to collect the MDG data at district level. MSH/USAID is working with the Ministry of Health to develop and field test methods for rapid assessment and improvement of the performance of obligatory functions and basic health services. In addition, MSH is strengthening information systems for surveillance and control of disease outbreaks and testing methods to measure district service functions.

5.4 Ensure resource allocation and improve funds channelling for priority health programs, especially for the poor

The Government of Indonesia has joined the international community in making commitments to reduce the impact of key conditions that comprise a large proportion of the global burden of disease and impose a costly burden on society. A major constraint is the continued low level of funding to the health sector. The Commission on Macroeconomics and Health estimates the cost of delivering a package of basic health interventions at US\$ 30–40 per person per year.^{xxxiii} Total government

spending on health, however, amounted to about US\$ 5.9 per person in 2001. From the international community, the contribution to health is similarly inadequate. Overseas development assistance to Indonesia averaged US\$ 1.5 billion annually in 2001.^{xxxiv} Of this amount, only 6% is dedicated to the health sector, and more than a quarter of these resources were spent on infrastructure.

There are a number of different means of funds channeling to health under a decentralized system, which include de-concentrated funds channeling via the central sectoral allocations in addition to decentralized block funding from the central level of the Ministry of Finance to district-level government. Almost all regions remain highly dependent on central level transfers, for an estimated 90% of their revenue. Furthermore, although the decentralized allocations are based on an equalization formula, the allocation does not provide sufficient funding to many districts to sustain pro-poor financing schemes.^{xxxv} Existing inequities exist in funds allocation processes. One equalization fund channeling mechanism cannot compensate for other existing channels of government funds based on historical precedent that are regressive; a simple increase in funds through the regressive channels maintains or increases inequities in resource distribution.

In increasing resources to the sector, it is important to match budget allocations with health priorities. This process may be facilitated via the enactment in 2004 of the State Finances Law, which delegates to sectoral ministries responsibilities for budget formulation and financial management, activities that are currently conducted by the Ministry of Finance. A mix of different strategies may be needed to ensure that such new sources of funding complement local revenues and can be earmarked for health. Obstacles to absorption and methods to increase absorption capacity should be identified. Increasing funds to the health sector will not achieve results without improved governance, such as transparency in the allocation and absorption of funds.

Progress to date. The Government of Indonesia has made international commitments to the MDGs, Healthy Environments for Children, International Conference on Population and Development, and the Framework Convention on Tobacco Control among others. Important fund channeling mechanisms, including the reallocation of fuel subsidies to poor areas, demonstrate the Government commitment to health care for the poor. A number of donors are supporting public expenditure reviews that provide a global picture of spending and resource allocation. In addition, donors are supporting in sectoral ministries strengthened financial management skills, including constraints in the expenditure process that inhibit implementation of the budget.

External support to the process. WHO, the World Bank, the Asian Development Bank and MSH are working on national health accounts and improving expenditure processes at national and district levels. The World Bank has examined public expenditures for health in detail in Sukabumi City and Aceh province, among its other projects areas, as an input to a comprehensive report on decentralization. GTZ is conducting a meta-analysis of all existing costing studies of health services in Indonesia, to examine both the methodology and results. The UN country cooperation system has funded a public expenditure review in the health sector to provide a global picture of spending and resource allocation. The Australian Agency for International Development (AusAID) has provided financial support to WHO to hire an international consultant in public finance for 11 months, to examine financial

flows within the Ministry of Health, constraints in the expenditure process that inhibit implementation of the budget, and to make recommendations about overcoming systemic constraints and innovative financial management mechanisms towards achieving specific health goals. WHO is currently conducting a public health expenditure review in Indonesia. The report will be completed in May 2004.

5.5 Ensure access to affordable, quality services, especially for the poor

The issue. Particularly in remote and sparsely populated areas with no alternatives for modern health care, publicly financed services are required. A minimum level of infrastructure and human resource investment needs to be established for such areas. Human resources, in particular, are the central input to an efficacious health system. The current ratio is about 1 physician per 6-7,000 persons. Providing incentives for posting qualified staff to remote areas remains an important challenge. The government's zero-growth policy in 1992 resulted in a decline in the rate of growth in the government workforce.

While a comprehensive human resource plan was developed in cooperation with the Healthy Indonesia 2010, this plan did not consider the skills and qualifications commensurate with new roles and responsibilities under a decentralized system at national, provincial, and district levels. Under decentralization, an estimated two thirds of the civil service, or about 2.1 million civil servants, were reassigned from central to regional levels. Conflicts exist, however, between the civil service law, which promotes a central civil services board, and decentralized personnel management structures in Law 22. Clearly, while the management of civil servants regionally is required to promote accountability under a decentralized system, there is also the need to ensure a central level role to promote mobility across regions and posting to remote and rural areas.

Current financial pressure at provincial level to reduce staffing numbers create high levels of insecurity, particularly since that is no plan to systematically evaluate qualifications and postings, redistribute or layoff staff. A critical evaluation of workforce needs, management, and deployment may offer an opportunity to address persistently low wages, particularly among peripheral level staff, which effectively prevent the development of a professional full-time cadre of health professionals and, in the long run, promote overstaffing in urban and highly populated areas where private practice may be more lucrative.

Progress to date. The Ministry of Health has used contracts to hire qualified staff, compared with lifetime civil service contracts. The Village Midwife Program (BDD) aimed to address the persistently high maternal mortality ratios by training and deploying an estimated 52,000 midwives to 96% of villages between 1989 and 1997. The midwives were not recruited into the civil service but rather worked as contracted employees (PTT) for a period of three years, with no guarantee of renewal. The expectation was that they would become independent village-based private providers after the completion of their contracts. Due to lack of demand, especially within poor villages, the BDDs remain under contract with the central Ministry of Health.

Another program was initiated in 1992, which contracted an estimated 2000 medical doctors and dentists during the 1990s. This program differed to the extent that the three-year contracts were mandatory, and only about 20-25% were offered civil

service employment after the completion of their contract. It appears that it did not succeed in encouraging medical providers to remain in remote areas, due in part to incentives that do not fully compensate for remote postings. Public staff were instead encouraged to set up private practices. In 1997, more than two thirds of health center heads (76.7%) also maintained a private practice. Among a large sample of private nurses, paramedics and midwives, the majority (66.7%) also worked in public health centers or hospitals.^{xxxvi} Although used as a pragmatic way to support public health staff in peripheral areas, the policy of allowing public staff to practice privately, within or outside of the public facility, encouraged private sector growth but may have provided dual incentives negatively impacting access. Overall, it appears that contracting qualified staff is an option within provinces with sufficient local revenues. Where local revenues are insufficient, the economic viability of programs such as the deployment of an additional peripheral level of minimally trained health workers, such as village midwives, has been questioned.^{xxxvii}

External support to the process. The US\$ 100 million provided through the World Bank health workforce project V (Jambi, East and West Kalimantan, and West Sumatra) has a central level component that aims to strengthen strategic health workforce planning. Another World Bank pilot program was conducted under their Safe Motherhood Project. The Target Based Performance Contracts (TPC) program was piloted in five districts each in East and Central Java, under which 105 village midwives signed performance-based contracts instead of renewing their PTT contracts. The TPC contracted midwives were paid for their services. If poor, pregnant women and women with children under 5 received services free of charge through a coupon mechanism. They were otherwise charged if they could afford to pay normal fees for service. Questions remain as to the success of this program in terms of targeting, impact and sustainability.^{xxxviii} WHO Indonesia has supported a nursing management pilot program in Yogya that aims to address the career development structures necessary to provide appropriate incentives and training for nurses concomitant with job expectations.

5.6 Ensure accountability by local government for health systems at all levels by engaging a broad range of stakeholders including the poor

The issue. Under decentralization also comes greater accountability to households and individuals, who require accurate information to make informed decisions about behaviors that affect health such as seeking quality care and medicine, smoking and exercise. There is a need to support the full and active participation of the community within priority setting, planning of health activities, and feedback into management, in addition to the promotion of active and well-educated consumers of care and providers of home care.

Progress and external support. Initiatives are underway, such as the World Bank-promoted District Health Councils, which can provide important lessons for replication.

6. Moving ahead

6.1 Overall direction

The overall direction of the MH work in Indonesia is necessarily broad and aims to take advantage of the ongoing policy processes. In general, MH support focuses on:

- **Promoting a common understanding** of the nature of poverty and health in Indonesia.
- **Developing broad partnerships** with other key government sectors, universities, local governments, communities, and private and non-governmental sectors to work together in achieving better health for the poor; and strengthening the mutual links.
- **Focusing resources** on public goods and addressing Indonesia's major health problems from which the poor suffer disproportionately, such as tuberculosis, malaria, malnutrition, and the provision of clean water, essential services and drugs.
- **Increasing effectiveness** via less emphasis on projects and more emphasis on sustainable policies and programs and cross-cutting issues such as the utilization of services by the poor.
- **Gaining the commitment** to significantly increase the level of investment in health as a vehicle to improve human development and reduce poverty.
- **Supporting effective decentralization** by emphasizing institutional and capacity development at all levels of the system, and systematically developing financing and delivery models for adaptation.

6.2 Activities in 2003-2004

Advocacy: Forum Parlemen. Stronger linkages with the NGO, Forum Parlemen, to support advocacy efforts among national and provincial legislators are being developed. The objective is *to increase knowledge and political commitment among policy makers, government officials, and the public about health, economic development, and poverty reduction to mainstream health into the national development agenda.* Activities in 2003-2004 include:

- a) Conducting District needs assessments via interactive dialogue with the local parliament members (Commission E and Budget Committee) and government (Pemerintah Daerah and Dinas Kesehatan) in 2003.
- b) Round table discussions with Commission 7, to increase understanding of key factors and strategies in addressing poverty and health, which will result in an Indonesian-specific Parliamentary call-for-action.
- c) Seminar on Macroeconomics and Health in the Parliament to disseminate and gain commitment within the parliament as a whole.

Empirical work that is being carried out include:

- Prioritization of health conditions from which the poor suffer disproportionately and public goods.
- Policy congruence both within the Ministry of Health and across government sectors.
- Financial vulnerability due to lack of protection from catastrophic health events.
- Concrete policy options to enhance the private sector contribution in achieving policy objectives. This will include an evaluation by a consultant of policy constraints in Indonesia's private health sector.
- Resource allocation methods and decision-making processes for government and donor aid. This will include an analysis of public health expenditures and their impact on service delivery outcomes and a review of financial management mechanisms.
- Human resource requirements in remote and rural areas

All empirical work will be translated into policy briefs for broad dissemination.

- ⁱ Bureau of Planning Ministry of Health trend data.
- ⁱⁱ National Family Planning Coordinating Board, 2000
- ⁱⁱⁱ Gertler and Molyneaux, 1994. How Economic Development and Family Planning Programs Combined to Reduce Indonesian Fertility. Demography This study demonstrated that 75% of the reduction in fertility in Indonesia was attributable to increased contraceptive use
- ^{iv} World Health Organization. 1997b. Primary Health Care Concepts and Challenges in a Changing World: Alma Ata Revisited. ARA Current Concerns Paper # 7. WHO/ ARA/ CC/ 97.1.
- ^v State Ministry for Population, 2000; World Bank, 1991 and 1999.
- ^{vi} World Bank Development Indicator Database.
- ^{vii} World Bank 2001 Watching Brief. Lieberman, Juwono, and Marzoeki.
- ^{viii} Chowdury, A and Sediati,G (2002) "Macroeconomic aspects of Poverty and Health in Indonesia", UNSFIR Working Paper: 02/06 and World Bank 1996, 2000
- ^{ix} See Chowdury, A and Sediati,G, 2002.
- ^x Bloom et al 2001 Working paper for the Commission on Macroeconomics and Health about the demographic transition.
- ^{xi} Sen, Amartya. 1999. Development as Freedom.
- ^{xii} Summary of findings from Alleyne and Cohen, April 20002, Health, economic growth and poverty reduction, Working paper for the Report on Macroeconomics and Health; and Hamoudi and Sachs, 1999; Economic Consequences of Health Status: A Review of the Evidence, Working paper for the Center for International Development, Harvard University.
- ^{xiii} Estimated incidence, all cases per 100,000 population. Global Tuberculosis Control, WHO 2002.
- ^{xiv} National estimation workshop on HIV/AIDs, April 2001, National AIDS Program, CDC, MoH.
- ^{xv} Dr. Soewarta Kosen, Oct 2003. The Burden of Malaria in Indonesia. Presentation to the seminar on Malaria and Poverty. MoH.
- ^{xvi} Gwatkin et al 2000. Socioeconomic Differences in health and education, World Bank.
- ^{xvii} Gwatkin et al 2000.
- ^{xviii} WHO and World Bank Development Indicators Database, data for 1999.
- ^{xix} Undang-Undang Nomor 25 Tahun 2000 tentang PROPENAS
- ^{xx} From the Interim Poverty Reduction Strategy Paper 2003; and Lampiran Tabel Rencana Program PK tahun 2004.
- ^{xxi} See Hammar 1996 for discussion of private insurance market failure.
- ^{xxii} Gertler and Gruber, 2002. Insuring Consumption Against Illness. Amer Econ Rev
- ^{xxiii} World Bank Poverty lines estimates: 2001
- ^{xxiv} WHO National health accounts data for Indonesia, 2000.
- ^{xxv} See Hammar 1996 for discussion of private insurance market failure.
- ^{xxvi} Gertler and Gruber, 2002. Insuring Consumption Against Illness. Amer Econ Rev
- ^{xxvii} World Bank Poverty lines estimates: 2001
- ^{xxviii} Askes, compulsory health insurance for civil servants, established since 1968, and JPK Jamsostek, compulsory employee health insurance. Both social health insurance schemes cover about 17 million people.
- ^{xxix} WHO National health accounts data for Indonesia, 2000.
- ^{xxx} Analysis of Susenas data 1990-2000. Marzolf 2002, The Indonesian Private Health Sector. World Bank
- ^{xxxi} A recent meeting in Ottawa, hosted by Canada, US, UK and World Bank, aimed to develop consensus on a framework for harmonized action to speed up country level efforts to achieve health related MDGs. The framework emphasized the need for more effective joint work at country level, evidence based action and results, and using existing instruments such as the Poverty Reduction Strategy. High level participation and commitments were made to follow up from 8 developing countries (including Indonesia under CIDA and DfID advocacy and sponsorship); 10 OECD countries; 6 UN system agencies; EU and Gates; GAVI, Global Fund, RBM and Stop TB partnerships.
- ^{xxxii} World Bank. 2003. Decentralizing Indonesia: A Regional Public Expenditure Review.
- ^{xxxiii} WHO 2001. Report of the Commission on Macroeconomics and Health.
- ^{xxxiv} OECD annual averages using data for 1998-2000, not including UN and EC contributions
- ^{xxxv} UNSFIR report: DAU 2002.
- ^{xxxvi} IFLS 1997.
- ^{xxxvii} World Bank 2000. Health strategy in a post-crisis decentralizing Indonesia.
- ^{xxxviii} World Bank. 2003.